## 25 YEAR RE-REVIEW

## S-E-C-R-E-T (When Filled In)

BRANCH THRU APPROPRIAT	JRN BOTH COPIES TO THE INSURANCE E ADMINISTRATIVE CHANNELS	
HOSPITALIZATION APPLICATION (CONTRACT PLAN)	DO NOT WRITE IN THIS BLOCK.  POLICY NO.  EFFECTIVE DATE	
*NAME OF		
EMPLOYEE		
(First) (Middle) (Last)	CODE_	
DATE OF BIRTH	TO DE COLDI EEED DY DEFECTOR	
MONTHLY PREMIUM	(TO BE COMPLETED BY DIVISION)	
MARRIED SINGLE	(PERSON TO CONTACT)	
SINGLE PLAN / FAMILY PLAN /	7	
FULL TIME EMPLOYEE / YES	(DIVISION) (EXT.)	
U.S. CIPIZEN TRESIDENT ALTEN		
	(ROOM NO ) (BLDC )	
☐ YES ☐ NO	AND DATE OF EMPLOYMENT AS CON- TRACT EMPLOYEE	
*PLEASE NOTE: "Name of Employee"	EMPLOYEE'S PAYROLL NO.	
and "Employee's Signature" should	The sound of the first two.	
agree with the one shown on contract	IS EMPLOYEE PAYROLLED	
with the Agency.	28 days [ ] Monthly [ ] Bi-weekly [ ]	
IF FAMILY PLAN, COMPLETE FOL	LOWING:	
NAME OF WIFE/HUSBAND		
(First)	(Middle Initial)	
CHILDREN UNDER 19 (A protected pe	erson's children shall include unmarried	
children under age 19. Also, any st	ep-children, legally adopted children, and	
foster children provided such childre	en are dependent upon the protected person	
for support and maintenance.)		
NAME DATE OF BIRT	HNAME DATE OF BIRTH	
I hereby authorize deductions from this contract.	my salary for payment of premiums under	
APPROVED:	*EMPLOYEE'S	
-	SIGNATURE	
	(See instructions above following*)	
Administrative Officer of Division	,	
	Date	

Approved For Release 2009/05/26 : CIA-RDP68-00140R000200180009-2

S-E-C-R B-I (When Filled In) S-E-C-R-E-T (When Filled In)

COMPLETE IN DUPLICATE & RETU	RN BOTH COPIES TO	THE INSURANCE	
BRANCH THRU APPROPRIATE	E ADMINISTRATIVE	CHANNELS	
HOSPITALIZATION APPLICATION	DO NOT WRITE IN THIS BLOCK.  POLICY NO.  EFFECTIVE DATE		
(CONTRACT PLAN)			
*NAME OF			
EMPLOYEE			
(First) (Middle) (Last)	CODE		
DATE OF BIRTH			
MONTHLY PREMIUM	TO BE COMPLET	ED BY DIVISION)	
MARRIED / SINGLE / 7			
J. HARLES J. J. SHAGISH J. J.	(PERSON TO CONT	(ACT)	
SINGLE PLAN / FAMILY PLAN /	77		
FULL TIME EMPLOYEE / YES / NO	(DIVISION)	(EXT.)	
U.S. CITIZEN TRESIDENT ALIEN			
COVERED BY PRESENT "10-UP" PLA	(ROOM NO.) (E	LOG,) LOYMENT AS CON -	
[7 YES [7 NO	TRACT EMPLOYEE		
*PLEASE NOTE: "Name of Employee"	EMPLOYEE'S PAY	ROLL NO.	
and "Employee's Signature" should			
agree with the one shown on contract	IS EMPLOYEE PA		
with the Agency.		28 days [ ] Monthly [ ]	
	Bi-weekly [		
IF FAMILY PLAN, COMPLETE FOLD	LOWING:		
NAME OF WIFE/HUSBAND (First)	/ NAS	ddle Initial)	
CHILDREN UNDER 19 (A protected pe	•	•	
children under age 19. Also, any st			
foster children provided such children			
for support and maintenance.)			
NAME DATE OF BIRT	HNAME	DATE OF BIRTH	
	on-sin - Museum numun under semente un september de planete autre des graves en comme que matéria habiteur - 19 mm 14 - 1		
I hereby authorize deductions from this contract.	my salary for paymer	nt of premiums under	
APPROVED:	*EMPLOYEE'S SIGNATURE		
	(See instructions ab	ove following*)	
Administrative Officer of Division			
	Date		
S-E	-C-R-E-T		

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